AHCCCS
Arizona Health Care Cost Containment System

Katie Hobbs, Governor
Carmen Heredia, Director

September 1, 2023

The Honorable David Livingston
Chairman, Joint Legislative Budget Committee
1700 W. Washington
Phoenix, AZ 85007

Dear Senator Livingston:

Pursuant to A.R.S. 36-3415, AHCCCS is required to report annually to the Joint Legislative Budget Committee on each fiscal year's Medicaid and non-Medicaid behavioral health expenditures, including behavioral health demographics that include client income, utilization and expenditures, medical necessity oversight practices, tracking of high-cost beneficiaries, mortality trends, placement trends, program integrity, and access to services.

If you have any questions regarding the attached report, please feel free to contact me at (602) 417-4711.

Sincerely,

Carmen Heredia
Director

cc: The Honorable John Kavanagh, Vice Chairman, Joint Legislative Budget Committee
Sarah Brown, Director, Governor's Office of Strategic Planning and Budgeting
Richard Stavneak, Director, Joint Legislative Budget Committee
Zaida Dedolph Piecoro, Health Policy Advisor, Office of the Governor

www.azahcccs.gov
602-417-4000
801 East Jefferson Street, Phoenix, AZ 85034

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BEHAVIORAL HEALTH ANNUAL REPORT

FOR THE PERIOD:
STATE FISCAL YEAR (SFY) 2022
(JULY 1, 2021 – JUNE 30, 2022)

September 2023
Carmen Heredia, Director

Background

The Arizona Revised Statute § 36-3415 requires the following report regarding members who received behavioral health services:

> *Behavioral health expenditures; annual report*
>
> *The administration shall report annually to the joint legislative budget committee on each fiscal year's Medicaid and non-Medicaid behavioral health expenditures, including behavioral health demographics that include client income, utilization and expenditures, medical necessity oversight practices, tracking of high-cost beneficiaries, mortality trends, placement trends, program integrity and access to services.*

Pursuant to Laws 2022, Second Regular Session, Chapter 305, this report is issued annually as the § 36-3415(A) report. Beginning in contract year ending (CYE) 2019, with the implementation of the AHCCCS Complete Care (ACC) program, AHCCCS Managed Care Organizations (MCOs) provide fully integrated physical and behavioral health care for members with General Mental Health/Substance Use (GMH/SU) needs and members who are children (except children who are in foster care). Effective with CYE 2020, members with developmental disabilities transitioned to fully integrated health plans contracted with the Department of Economic Security/Division of Developmental Disabilities (DES/DDD) for acute care and behavioral health services. Members enrolled in the Comprehensive Medical and Dental Program (CMDP) were transitioned to an integrated product part way through SFY 2021, effective April 1, 2021. Under its new name, the Arizona Department of Child Safety, Comprehensive Health Plan (DCS CHP) delivers integrated physical and behavioral health services to its members. Information in previous reports usually reflected RBHA data only, information in this year's report is inclusive of behavioral health (BH) services provided under all contracts.

AHCCCS reports behavioral health service data as defined by clinical criteria determined by AHCCCS, instead of reporting behavioral health expenditures incurred only by ACC-RBHA payers for the reasons noted above. This reporting methodology was previously implemented for the Behavioral Health Enrolled and Served report that is produced on a monthly basis pursuant to § 36-3405(D) as described in a clinical criteria memorandum available on the AHCCCS website.

Client Income

AHCCCS members who receive Medicaid services generally have household incomes near or below the Federal Poverty Level (FPL) and Federal Benefit Rate (FBR). The FBR standards usually change in January each year, and the FPL standards change no later than April each year. The FPL and FBR standards used for the eligibility determinations in State Fiscal Year 2022 can be found on the AHCCCS website, under the Medical Assistance Eligibility Policy Manual.

In SFY 2022, 100% FBR for an individual was $10,092 a year and 100% FPL for an individual was $13,596 a year. As noted in Table I, 40.1% of Medicaid (Title XIX) and Children's Health Insurance Program (CHIP – Title XXI) members determined by FPL were below 100% FPL. In addition, AHCCCS provides some limited, Non-Title XIX/XXI services to individuals not eligible for Medicaid/CHIP, who may have higher household incomes.

Table II presents the percentage of members determined by FBR. In SFY 2022, 72.1% of Medicaid and CHIP members determined by FBR were below 100% FBR.

Table I - Medicaid & CHIP Members Determined by FPL* - SFY 2022

Federal Poverty Level	Percent
< 36% FPL	9.6%
≥ 36% and < 40% FPL	30.4%
≥ 40% and < 106% FPL	39.0%
≥ 106% and < 120% FPL	2.2%
≥ 120% and < 133% FPL	10.1%
≥ 133% and < 150% FPL	0.8%
≥ 150% and <185% FPL	5.6%
≥ 185% and < 200% FPL	2.4%
≥ 200% and < 250%FPL	0.02%
Grand Total	**100%**

*Codes for FPL bands are adjusted annually.

Table II - Medicaid & CHIP Members Determined by FBR - SFY2022

Federal Benefit Rate	Percent
< 100% FBR	72.1%
≥ 100% and < 300% FBR	27.9%
Total	**100.0%**

Utilization and Expenditures

The Medicaid and non-Medicaid behavioral health expenditures for SFY 2022 are provided in Tables III and IV. These expenditures are consistent with those reported in AHCCCS' SFY 2022 Behavioral Health Programmatic Expenditure Report, submitted in accordance with A.R.S. § 36-3405.

In this report, behavioral health services are defined as any service with a primary diagnosis code that is behavioral health related, or a pharmacy claim that is behavioral health related, as defined by AHCCCS clinical criteria. Expenditures data includes MCOs and Fee-For-Service (FFS) providers.

Medicaid Federal Grant Awards reported in Table III reflect an allocation of total payments based on the behavioral health proportional component of the total per member per month capitation rate. All other reported source amounts are actuals. Expenditures are reported on a cash basis that can result in timing differences between the receipt of funds and actual cash disbursements.

Table III - Statewide Expenditures by Funding Source – SFY 2022

Total Behavioral Health Services Expenditures by Funding Source FY 2022		
Funding	**Amount Paid**	**Percentage**
General Fund - Medicaid	$574,797,708	15.5%
Tobacco Tax Funds – Medically Needy Account	$35,565,800	1.0%
Tobacco Tax Funds –Proposition 204 Protection Account	$5,000,000	0.1%
Tobacco Tax Funds –Tobacco Litigation Settlement	$30,154,400	0.8%
TXIX and TXXI Medicaid Federal Grant Awards	$2,790,722,940	75.1%
Non TXIX General Fund	$97,970,865	2.6%
Substance Abuse Services Fund	$2,250,200	0.1%
Federal Grant - MHBG	$17,734,510	0.5%
Federal Grant - SABG	$41,063,557	1.1%
Federal Grants (Opioid/Other)	$43,566,078	1.2%
County Funds	$75,061,691	2.0%
SMI Housing Trust Fund	$1,346,015	0.04%
Substance Use Disorder Funds	$2,624,312	0.1%
Other (Liquor Service Fees)	$126,746	0.0%
Total	**$3,717,984,821**	**100.00%**
TXIX/TXXI	**$3,436,240,847**	**92.42%**
Non-TXIX/Non-TXXI	**$281,743,973**	**7.58%**

The reported expenditures in Table IV are a further allocation of the figures from Table III, based on the proportional use by service during the time period.

Table IV - Statewide Expenditures by Behavioral Health Category – SFY 2022*

Total Behavioral Health Services Expenditures by Behavioral Health Category FY 2022			
Behavioral Health Category	**TXIX/TXXI Funding**	**Non-TXIX/ Non-TXXI Funding**	**Total**
Seriously Mentally Ill	$763,470,677	$119,005,855	$882,476,532
Children with Severe Emotional Disturbance	$344,572,933	$16,885,736	$361,458,669
Alcohol and Drug Abuse	$866,076,934	$47,551,657	$913,628,591
Other Mental Health	$1,462,120,303	$98,300,726	$1,560,421,029
Total	**$3,436,240,847**	**$281,743,973**	**$3,717,984,821**

**Table IV includes only Title XIX and Title XIX Funding Sources*

Medical Necessity Oversight Practices

AHCCCS requires providers to deliver covered services to AHCCCS members in accordance with all applicable federal and state laws, the Arizona Section 1115 Waiver Demonstration, regulations, contract, and policy. In addition, services must meet mental health parity standards, which generally require limitations applied to mental health/substance use disorder benefits be no more restrictive than limitations applied to medical conditions/surgical procedure benefits. Covered services must be medically necessary and be provided by a qualified provider.

AHCCCS contracts require MCOs to develop a comprehensive Medical Management (MM) Program that will assure the appropriate management of service delivery for members. Each MCO's MM Program is comprised of numerous required elements including policies, procedures, and criteria for the following activities that support medical necessity oversight:

- **Prior authorization (PA)** - The PA process promotes appropriate utilization of services, including behavioral health services, while effectively managing associated costs (though many behavioral health services do not require PA). PA decisions are made by a qualified health care professional with the appropriate clinical expertise in treating the member's condition or disease and will render decisions that:
    - Approve the request,
    - Deny a request based on medical necessity,
    - Authorize a request in an amount, duration, or scope that is less than requested, or
    - Exclude or limit services.

  A denial, reduction, limited authorization, or termination of a covered service requires that a Notice of Adverse Benefit Determination be issued to the member.

- **Concurrent and retrospective review** - AHCCCS policy outlines specific required criteria for utilization of services in institutional settings (e.g., hospitals, behavioral health residential facilities, etc.). MCOs must include these elements in policies and procedures. These reviews address medical necessity prior to a planned admission and determine medical necessity for continued stay.

- **MM utilization data analysis and data management** – MM uses analysis and management of data to focuses on the utilization of services to detect both the under- and over-utilization of services. The MCO reviews and evaluates the data and implements actions for improvement when variances are identified.

Oversight Activities

AHCCCS monitors and oversees MCO MM activities including an annual MM plan submission, quarterly PA approval and denial data, and Operational Reviews (OR) that audit the MCOs' compliance with established AHCCCS MM standards. The ORs measure compliance towards the following practices: PA, concurrent and retrospective review, Notices of Adverse Benefit Determination, evidence-based guidelines, inter-rater reliability, and drug utilization review.

During the COVID-19 Public Health Emergency (PHE), AHCCCS granted concurrent review flexibility, which relaxed some MM requirements, causing a decrease in PA, NOA, and other review activities from the prior reporting period. These temporary policy modifications expired in October 2022. AHCCCS provided technical assistance to the MCOs to refine their reporting on PAs, Notice of Adverse Benefit Determinations, and concurrent and retrospective reviews after concurrent flexibility ended. AHCCCS will monitor reporting to ensure data integrity and provide additional technical assistance as warranted.

Table V offers data on the volume of behavioral health specific MCO MM oversight activities during SFY 2022.

Table V – MCO Behavioral Health Medical Necessity Oversight Activities - SFY 2022

Behavioral Health Medical Necessity Oversight Activity	SFY 2022
Prior Authorizations	2,821
Notice of Adverse Benefit Determinations (NOA)	254
Concurrent Reviews	8,111
Retrospective Reviews	162

Utilization Analysis

AHCCCS utilizes standardized performance measures to monitor MCO compliance with delivery of care standards. Performance measures may focus on clinical and non-clinical measures for both physical and behavioral health services.

Table VI provides the most recent behavioral health utilization performance measure data, for CY 2021 (January 1, 2021 to December 31, 2021). AHCCCS calculates performance measures on a Calendar Year (CY) to align with the most current available federal fiscal year performance standards.

Table VI – AHCCCS Performance Measure Data – Utilization of Services

CY 2021 Behavioral Health Performance Measure Rates				
Performance Measure	**2021 NCQA Medicaid Mean[1]**	**ACC Aggregate**	**SMI Aggregate**	**Statewide[2] Aggregate**
Mental Health Utilization - Any Service	NA[3]	10.3%	81.8%	13.8%
Mental Health Utilization - Inpatient	NA[3]	1.0%	18.1%	1.5%
Mental Health Utilization - Intensive Outpatient/Partial Hospitalization	NA[3]	0.3%	12.7%	0.8%
Mental Health Utilization - Outpatient	NA[3]	9.4%	79.4%	12.6%
Mental Health Utilization - ED	NA[3]	0.0%	0.4%	0.1%
Mental Health Utilization - Telehealth	NA[3]	2.4%	16.6%	3.4%
Use of Pharmacotherapy for Opioid Use Disorder	NA[3]	59.6%	38.2%	51.7%
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics	58.6%	67.8%	NA[4]	67.4%

[1] *NCQA Medicaid Mean retrieved from the State of Health Care Quality Report published by NCQA.*
[2] *Rates reflective of all managed care enrolled members meeting continuous enrollment criteria regardless of line of business.*
[3] *Measure does not have an NCQA Medicaid Mean.*
[4] *SMI does not include children and adolescents.*

Most of the utilization measures in Table VI utilization declined or remained flat when compared to the prior year, consistent with broader utilization trends as a result of Public Health Emergency beginning in March 2020. One exception was the Use of Pharmacotherapy for Opioid Use Disorder. The performance increased in this measure for both the ACC and SMI Aggregate when compared to the prior year. AHCCCS will continue to monitor these measures to ensure availability and access to behavioral health services.

In efforts to promote improvement in performance measure rates, AHCCCS requires contractors to implement corrective action plans (CAPs) for measures not meeting the associated performance measure standards.

High-Cost Beneficiaries

AHCCCS requires MCOs to coordinate care for members with high behavioral and physical health needs and/or high costs. The MCO must identify members with high needs/high costs (HNHC), plan interventions for addressing appropriate and timely care for these members, and report outcomes to AHCCCS. MCOs track interventions based on standardized criteria and report intervention summaries to AHCCCS within the annual plan submissions.

Beginning in CYE 2020, AHCCCS removed its prescriptive requirements for identifying high need/high-cost members and allowed MCOs to develop their own criteria. MCOs took this opportunity to expand the diagnoses used to identify such members who could benefit from greater care coordination.

AHCCCS implemented a behavioral health specific deliverable associated with AHCCCS Medical Policy Manual (AMPM) 1021 during SFY 2022. MCOs identified and tracked 1,839 behavioral health high-cost beneficiaries in SFY 2022. AHCCCS will continue to monitor future deliverable submissions to ensure data integrity and will provide additional technical assistance as warranted.

Mortality Trends

AHCCCS obtained member mortality data via an inter-agency agreement with the Arizona Department of Health Services (ADHS), which includes Manner of Death (MOD). Table VII presents 488 mortalities statewide for children under the age of 18 receiving behavioral health services. The MOD was natural death for 186 deaths which equated to 38% of deaths in SFY 2022 and accidents accounted for 115 deaths or 24%. Suicide was the MOD for 13 or 2.7% of deaths.

Table VII - Mortality Trends – Child

Member Manner of Death SFY2022	TXIX	%	NTXIX	%	All Child	%
Accident	114	23.5%	1	50.0%	115	23.6%
Homicide	35	7.2%	0	0.0%	35	7.2%
Natural Death	186	38.3%	0	0.0%	186	38.1%
Pending Investigation	0	0.0%	0	0.0%	0	0.0%
Suicide	12	2.5%	1	50.0%	13	2.7%
Undetermined	44	9.1%	0	0.0%	44	9.0%
Unknown	95	19.6%	0	0.0%	95	19.5%
Total	**486**	**100.0%**	**2**	**100.0%**	**488**	**100.0%**

Table VIII presents 21,062 mortalities statewide for adult members with a General Mental Health and/or Substance Use Disorder (GMH/SUD). The MOD was natural death for 16,606 members which equated to 79% of deaths in SFY 2022, and accidents accounted for 2,670 or 13%. Suicide was the MOD for 481 or 2% of deaths for this population.

Table VIII – Mortality Trends - General Mental Health/Substance Use (GMH/SUD)

Member Manner of Death SFY2022	TXIX	%	NTXIX	%	All GMH/SU	%
Accident	2,533	12.5%	137	15.8%	2,670	12.7%
Homicide	335	1.7%	13	1.5%	348	1.7%
Natural Death	15,971	79.1%	635	73.1%	16,606	78.8%
Pending Investigation	23	0.1%	0	0.0%	23	0.1%
Suicide	416	2.1%	65	7.5%	481	2.3%
Undetermined	155	0.8%	7	0.8%	162	0.8%
Unknown	760	3.8%	12	1.4%	772	3.7%
Total	**20,193**	**100.0%**	**869**	**100.0%**	**21,062**	**100.0%**

As shown in Table IX, of the 1,769 mortalities for adult members with a SMI designation, the MOD was natural death for 1,148 members which equated to 65% of deaths, and accidents accounted for 434 or 25% of deaths. Suicide was the MOD for 86 or 5% of deaths for these members in SFY 2022.

Table IX - Mortality Trends – Members with a Serious Mental Illness (SMI)

Member Manner of Death SFY2022	TXIX	%	NTXIX	%	All SMI	%
Accident	370	25.3%	64	20.9%	434	24.5%
Homicide	23	1.6%	3	1.0%	26	1.5%
Natural Death	939	64.3%	209	68.1%	1,148	64.9%
Suicide	72	4.9%	14	4.6%	86	4.9%
Undetermined	22	1.5%	8	2.6%	30	1.7%
Unknown	35	2.4%	10	3.3%	45	2.5%
Total	**1,461**	**100.0%**	**308**	**100.0%**	**1,769**	**100.0%**

Table X illustrates statewide trends for death for all members receiving behavioral health services including Child, GMH/SUD and SMI populations.

Table X - Mortality Trends – Statewide Behavioral Health Members

Statewide Manner of Death SFY2022	TXIX	%	NTXIX	%	All SMI	%
Accident	3,017	13.6%	202	17.2%	3,219	13.8%
Homicide	393	1.8%	16	1.4%	409	1.8%
Natural Death	17,095	77.2%	844	71.7%	17,939	76.9%
Pending Investigation	24	0.1%	0	0.0%	24	0.1%
Suicide	500	2.3%	80	6.8%	580	2.5%
Undetermined	221	1.0%	15	1.3%	236	1.0%
Unknown	887	4.0%	21	1.8%	908	3.9%
Total	**22,137**	**100.0%**	**1,178**	**100.0%**	**23,315**	**100.0%**

Table XI illustrates the mortality rate per 1000 Behavioral Health Members The natural death MOD category demonstrated the highest rate per one thousand members for all behavioral health populations. This is the first year AHCCCS is reporting MOD based on the mortality data sharing agreement between AHCCCS and ADHS, and the SFY 2022 mortality data will be utilized as baseline data for comparison in future reports. AHCCCS will continue to monitor mortalities for these populations over time.

Table XI - Mortality Trends for Behavioral Health Members – Rate Per 1000 Members

Statewide Manner of Death SFY2022	All Child		All GMH/SUD		All SMI		STATEWIDE	
	# of Mortalities	Rate per 1000	# of Mortalities	Rate per 1000	# of Mortalities	Rate per 1000	# of Mortalities	Rate per 1000
Accident	115	1.4	2,670	13.8	434	6.6	3,219	9.4
Homicide	35	0.4	348	1.8	26	0.4	409	1.2
Natural Death	186	2.3	16,606	85.5	1,147	17.5	17,939	52.6
Pending Investigation	0	0.0	23	0.1	1	0.02	24	0.07
Suicide	13	0.2	481	2.5	86	1.3	580	1.7
Undetermined	44	0.5	162	0.8	30	0.5	236	0.7
Unknown	95	1.2	772	4.0	41	0.6	908	2.7
Total	**488**	**6.0**	**21,062**	**108.5**	**1,765**	**26.9**	**23,315**	**68.3**

Placement Trends

A number of behavioral health treatment settings exist for AHCCCS members. MCOs place a member in the least restrictive setting that is most appropriate for the level of care needed for the specific situation. These settings include[1]:

- Behavioral Health Residential Facility (BHRF):
  Residential services provided by a licensed behavioral health agency. These agencies provide a structured treatment setting with 24-hour supervision and counseling or other therapeutic activities for persons who do not require on-site medical services, under the supervision of an on-site or on-call behavioral health professional.

- Therapeutic Foster Care:
  Therapeutic Foster Care services, formerly known as Home Care Training, to Home Care Client (HCTC) services, care provided by a behavioral health therapeutic home to a person residing in their home in order to implement the in-home portion of the person's behavioral health service plan. Therapeutic foster care services assist and support a person in achieving their service plan goals and objectives. It also helps the person remain in the community setting, thereby avoiding residential, inpatient, or institutional care.

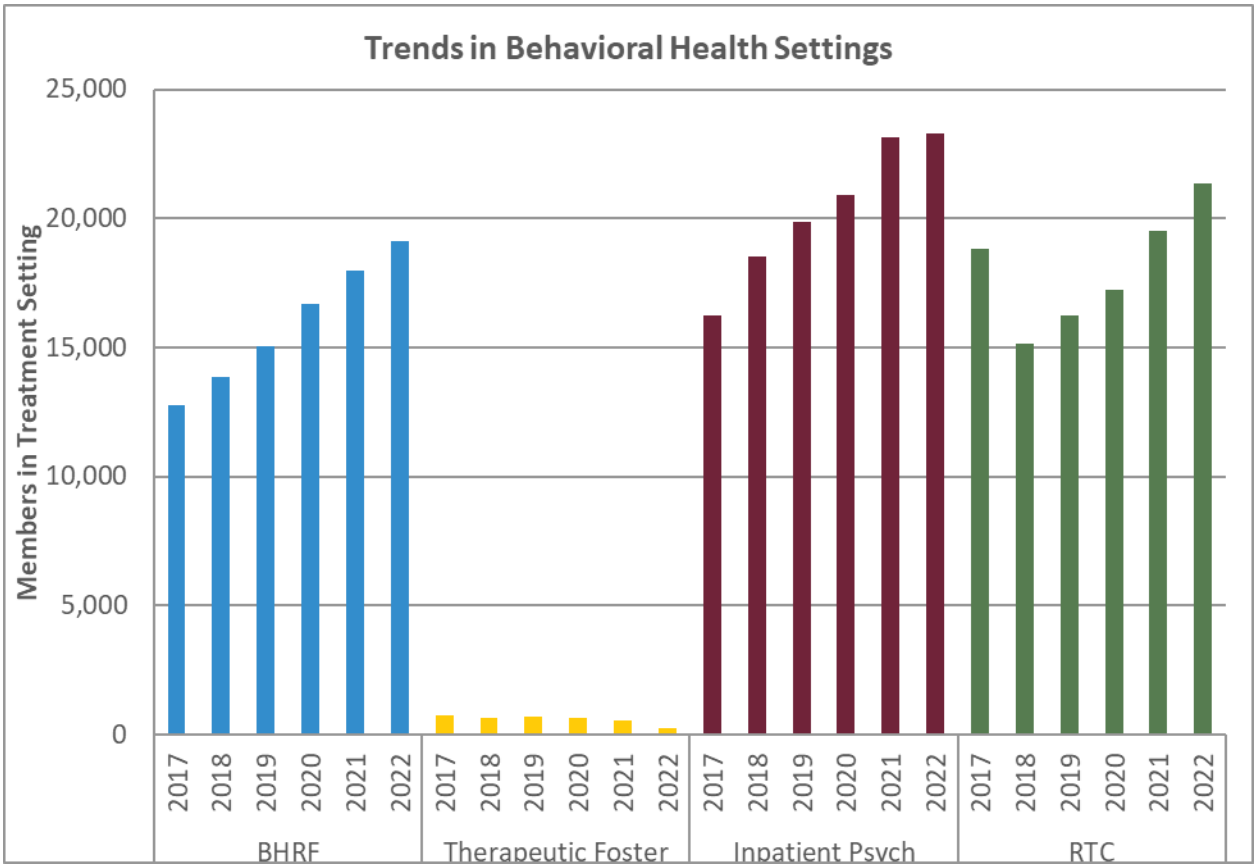
[1] More details regarding these treatment settings can be found in Chapter 300 of the AHCCCS Medical Policy Manual.

- Inpatient Psychiatric Hospital:
  Inpatient services (including room and board) provided by a licensed behavioral health agency. These facilities provide a structured treatment setting with 24-hour supervision and an intensive treatment program, including medical support services.

- Residential Treatment Center (RTC):
  Inpatient psychiatric treatment, which includes an integrated residential program of therapies, activities, and experiences provided to persons who are under 21 years of age and have severe or acute behavioral health symptoms.

Chart I provides a six-year history of behavioral health treatment settings for AHCCCS members. AHCCCS provides the data on a CYE basis (October 1 through September 30 annually).

Chart I – Trends in Behavioral Health Settings



A combination of factors helps explain the trends in treatment settings over the last six years.

AHCCCS and its MCOs recognized the need for increasing network capacity for BHRF services and supported efforts by the provider community to add beds in this treatment setting. Some of the factors contributing to the need for additional beds include:

- Members leaving jail and transitioning to medically necessary behavioral health care in the community,

- Greater focus on treatment for opiate use disorder to reduce opioid prescription drug misuse and abuse,
- Programs targeting specialty populations in the children's system, for example youth with developmental delays exhibiting sexually maladaptive behaviors, and
- Expansion for the inclusion of personal care services for members determined SMI, when appropriate.

Several factors contributed to increased utilization of inpatient services across populations including, but not limited to:

- Collaboration with first responders, including expanded crisis intervention training to support police officers in getting members to treatment rather than sending members to jail,
- Concentrated efforts to reduce emergency department holds, which resulted in members obtaining inpatient care more quickly and enabling easier access to inpatient services,
- Greater focus on inpatient treatment for opiate use disorder to reduce opioid prescription drug misuse and abuse,
- Development of special needs units for youth with autism increasing the number of available behavioral beds in the community, and
- Increased capacity to manage crisis-related treatment statewide.

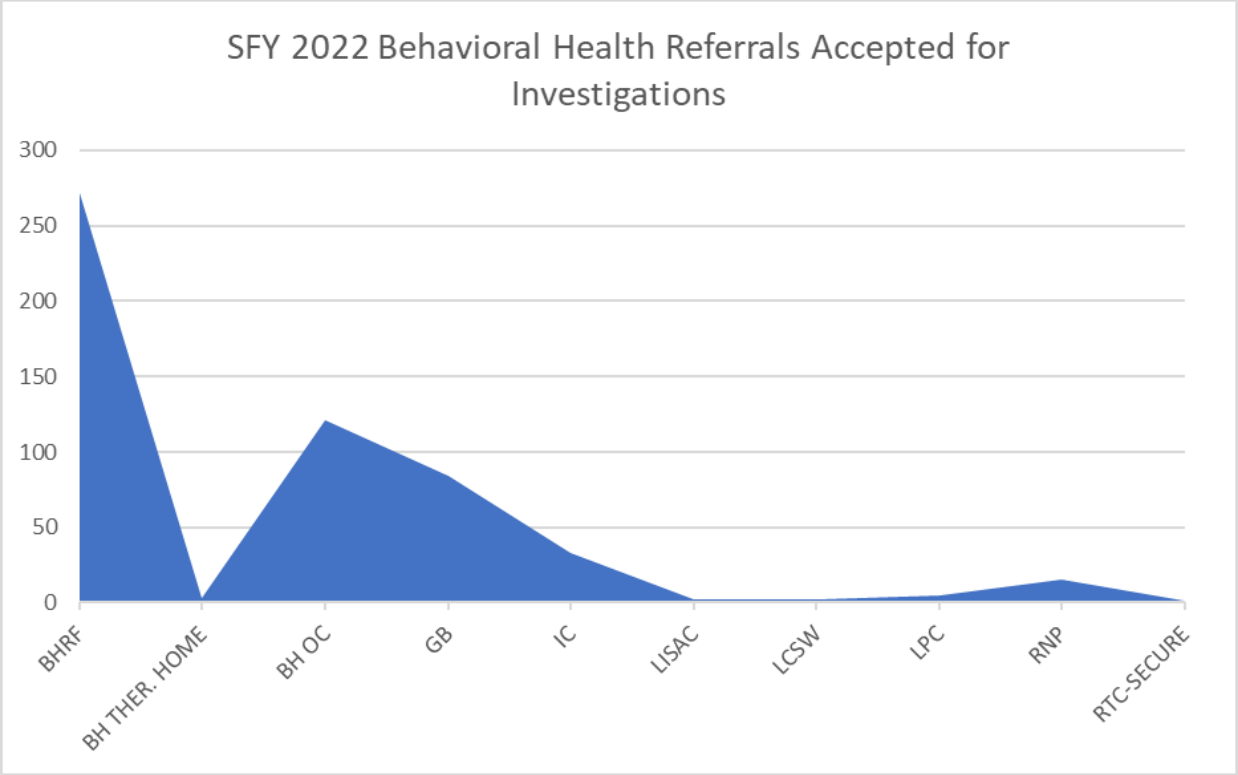
Program Integrity

The AHCCCS Office of the Inspector General (OIG) is responsible for the integrity of the AHCCCS budget, nearly $22 billion in State Fiscal Year 2023. It exists to prevent, detect, and recover improper payments due to Medicaid fraud, waste, and abuse. At the end of SFY22, AHCCCS had 2,411,057 beneficiaries, 120,566 providers, and 47 OIG investigators. OIG achieved $48,123,165.28 in savings and recoveries during SFY22.

OIG's program integrity activities included a developed focus on behavioral health services due to the fraud currently occurring in Arizona during SFY 2022. OIG has continued to develop its previously reported behavioral health cases and investigations [see Behavioral Health Reports SFY 21, SFY 20]. During SFY22, OIG opened investigations on:

- Behavioral Health Residential Facilities
- Behavioral Health Therapeutic Home
- Behavioral Health Outpatient Clinic
- Group Billers
- Integrated Clinics
- Licensed Independent Substance Abuse Counselor
- Licensed Clinical Social Worker
- Licensed Professional Counselor
- Registered Nurse Practitioner
- Residential Treatment Center-Secure

Chart II – Behavioral Health Referrals Accepted for Investigations

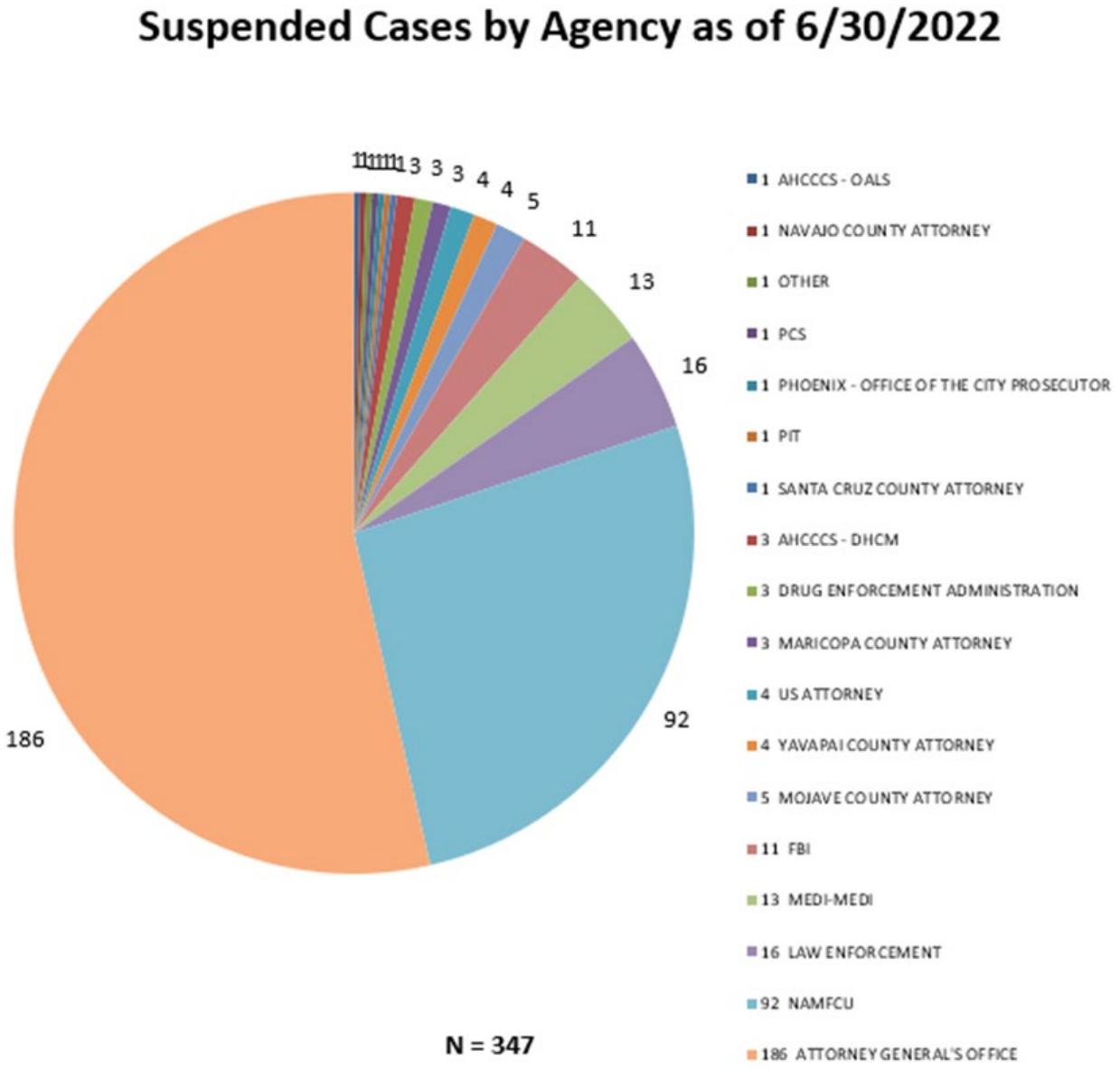


Under 42 C.F.R. § 455.23 and the terms of the Provider Participation Agreement, AHCCCS may suspend payments to a provider if a Credible Allegation of Fraud (CAF) has been identified. Providers are informed of the reason for their suspension in a Notice of CAF Suspension. CAF suspensions are based on preliminary findings of reliable indicia of fraud and may be lifted if AHCCCS determines there is no fraud occurring and/or good cause has been established under 42 C.F.R. § 455.23. Since first reporting the behavioral health fraud schemes for this report in SFY 2020, OIG has instituted more than 240 Credible Allegation of Fraud payment suspensions, with 22 of those CAF Payment Suspensions occurring during SFY 2022.

In addition to the partnerships needed to perform CAF payment suspensions, OIG has worked collaboratively during SFY 2022 with several law enforcement agencies, such as: the Arizona Attorney General's Office Health Care Fraud and Abuse section (AGO HCFA), the Federal Bureau of Investigation (FBI), the Internal Revenue Service (IRS), and Health and Human Services Office of Inspector General (HHS OIG). These collaborations and partnerships are imperative for the protection of Arizona's Medicaid dollars and extend beyond simple information sharing. OIG and AGO HCFA presented nationally to all 56 states and territories on *A Comprehensive Approach to Stopping Behavioral Health Medicaid Fraud* at the NAMPI conference. This national platform has helped Arizona share pertinent behavioral health information, best practices, and investigative approaches with other State Medicaid Agencies (SMAs).

As of the end of SFY 22, OIG had 347 open investigations with several different law enforcement agencies. Note: These investigations are not all behavioral health specific.

Chart III – Suspended Cases by Agency



OIG Behavioral Health cases in the news for investigations involving SFY22 include:

- Attorney General Mark Brnovich Announces 13 Individuals and 14 Related Business Entities Indicted in Alleged Massive Health Care Fraud Billing Scheme
- Mesa Woman Pleads Guilty to Fraud Targeting AHCCCS
- Chandler Couple Arrested for AHCCCS Fraud and Pandemic Loan Fraud

Internally, OIG has maintained its extensive cross divisional reporting with different AHCCCS divisions, including but not limited to; AHCCCS Division of Fee for Service Management (DFSM), AHCCCS Division of Health Care Management (DHCM), AHCCCS Division of Business and Finance (DBF), AHCCCS Information Services Division (ISD), and the AHCCCS Division of Member and Provider Services (DMPS). Subject matter

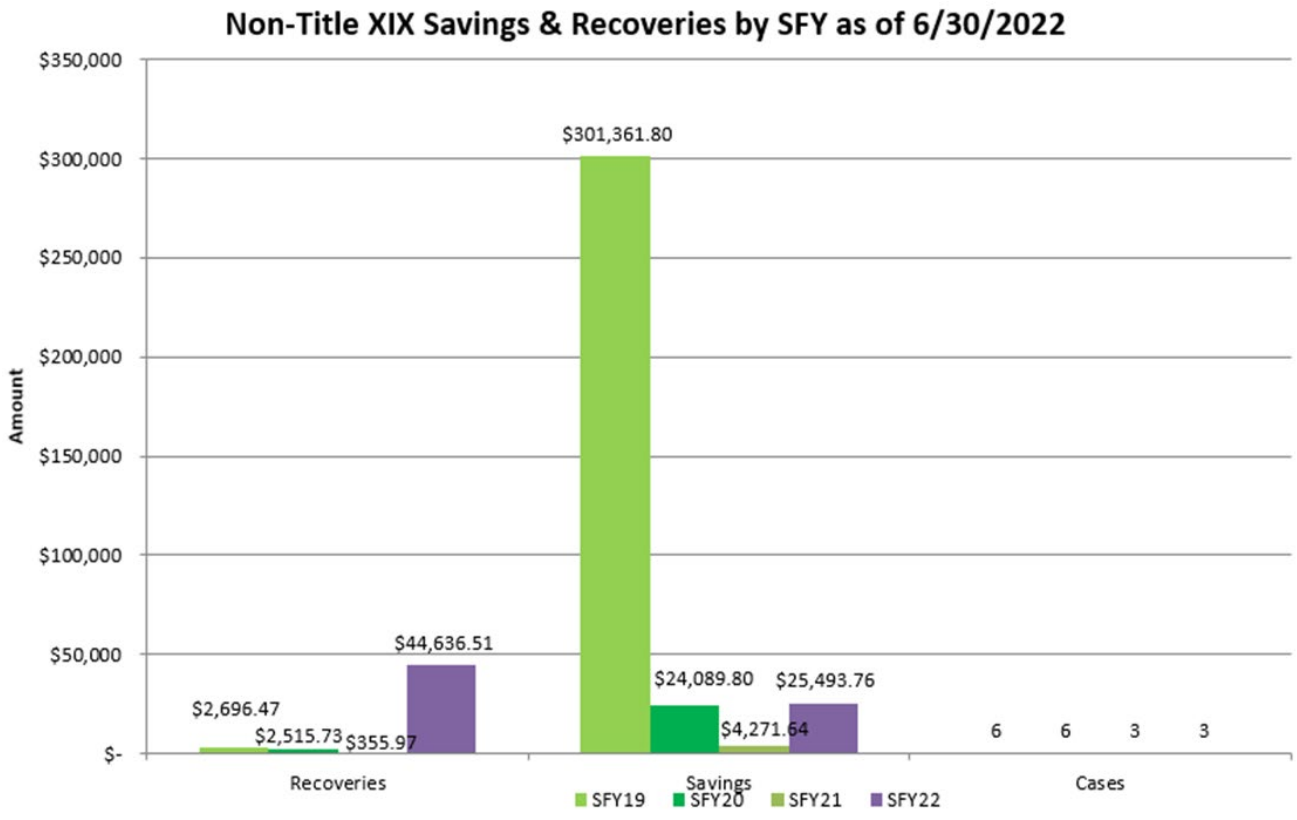
experts' contributions from each of these areas have helped OIG perform comprehensive fact findings, gather evidence, and develop investigative leads.

OIG instituted a licensure inspection during SFY22. Due to this review, OIG terminated 92 Behavioral Health Residential Facilities registered with AHCCCS without current and appropriate licensure during SFY22. These terminations resulted in $12,070,747.63 in savings to the AHCCCS program. As a result of this project, OIG has expanded its licensure review to other behavioral health provider types.

OIG and the Arizona Department of Health Services (ADHS) worked collaboratively during SFY22. ADHS is an agency in the State of Arizona established to promote and protect public health and welfare through the operation of health-related programs within the state. The shared information and partnerships lead to the development of an MOU between our two agencies. While the executed MOU fell outside of the period for SFY22, the groundwork leading to this agreement started during this time. The development of information sharing between OIG and ADHS has proven essential and continues to expand.

Aside from these cases, OIG can identify separate instances of recoveries and savings solely used for the provision of behavioral health services which are funded with Non-Title XIX funds. OIG achieved $70,130.27 in savings and recoveries of NTXIX cases during SFY22.

Chart IV – Non-Title XIX Savings and Recoveries by SFY



Access to Services

Access to care is a pillar of the Medicaid program, focused on members' ability to obtain quality health services in a timely manner to achieve optimal health outcomes. It is measured by the availability, accessibility, and adequacy of services. AHCCCS has established standards and requirements for MCOs to ensure members have access to care.

Network

AHCCCS requires MCOs to develop and maintain a comprehensive provider network. MCOs must develop a provider Network Development and Management Plan that assures the provision of covered services. The Plan outlines the process to develop, maintain, and monitor an adequate provider network, supported by written agreements, demonstrating sufficient access to all services covered under the contract.

MCOs' contracted providers must meet AHCCCS appointment availability and minimum network standards. Network standards include minimum time or distance standards for various provider types, including Behavioral Health Outpatient and Integrated Clinics (for adult and pediatric populations) and Crisis Stabilization facilities as outlined in the AHCCCS Contractor Operations Manual.

The MCOs submit reporting on these time and distance standards, which AHCCCS validates through an External Quality Review Organization (EQRO). If the MCO fails to meet a time and distance standard, AHCCCS provides the MCO with a list of AHCCCS-registered providers in or near the county that are currently not in the MCO's network. Similar information is supplied to DES/DDD to assist it with its subcontracted MCOs. Continued failure to meet the standard can result in compliance action under the MCO's contract. Tables XII through XVII on the following pages illustrate the validated findings for the MCO performance against established network requirements for Behavioral Health Outpatient and Integrated Clinics (adult and pediatric populations), and Crisis Stabilization facilities. The ACC MCOs are identified by an '(A)' in the tables below, the ACC-RBHAs by an '(R)', ALTCS/EPD plans with an (L), and DES/DDD subcontractors with a (D).

The time and distance data below represents performance during State Fiscal Year 2022. During that time, there were several changes that impacted the results. Effective October 1, 2021, due to the acquisition of Care1st's parent company by the parent company of Arizona Complete Health, members enrolled in Maricopa, Pinal, and Gila counties transitioned to Arizona Complete Health. As a result, the performance reported for Care1st in these counties is based upon the reporting period prior to the transition. Additionally, after October 1, 2021, AHCCCS incorporated telehealth into its time and distance standards. Specifically, for Behavioral Health Outpatient and Integrated Clinics (for adult and pediatric populations), AHCCCS considered an MCO in compliance with time and distance standards if 80% of members lived within a county's time and distance requirements if services via telehealth are available to members in the county.

Table XII – ACC-RBHA Behavioral Health Outpatient/Integrated Clinics (Adults)

ACC-RBHA Behavioral Health Outpatient/Integrated Clinics (Adults)			
SFY 2022			
County/Requirement	Mercy Care (R)	Health Choice Arizona (R)	Arizona Complete Health (R)
Maricopa - 90% within 15 min or 10 miles	99.0%		
Pima - 90% within 15 min or 10 miles			98.2%
Apache - 90% within 60 miles		96.5%	
Coconino - 90% within 60 miles		99.4%	
Gila - 90% within 60 miles		100.0%	
Mohave - 90% within 60 miles		100%	
Navajo - 90% within 60 miles		99.4%	
Yavapai - 90% within 60 miles		100.0%	
Yuma - 90% within 60 miles			99.3%
Pinal - 90% within 60 miles			100.0%
Cochise - 90% within 60 miles			100.0%
Santa Cruz - 90% within 60 miles			100.0%
Graham - 90% within 60 miles			100.0%
La Paz - 90% within 60 miles			100.0%
Greenlee - 90% within 60 miles			100.0%

Percent Compliant
90- 100%
80-89.9%
Under 80%
MCO Not in County

Table XIII - ACC Behavioral Health Outpatient/Integrated Clinics (Adults)

ACC Behavioral Health Outpatient/Integrated Clinics (Adults)							
SFY 2022							
County/Requirement	Mercy Care (A)	Health Choice Arizona (A)	Arizona Complete Health (A)	Banner UFC (A)	Care1st (A)	Molina Complete Care (A)	United Health Care (A)
Maricopa - 90% within 15 min or 10 miles	98.6%	98.7%	98.9%	99.3%	99.1%	98.8%	99.5%
Pima - 90% within 15 min or 10 miles			97.1%	97.4%			96.6%
Apache - 90% within 60 miles		85.0%			76.1%		
Coconino - 90% within 60 miles		97.5%			98.2%		
Gila - 90% within 60 miles	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Mohave - 90% within 60 miles		99.9%			99.9%		
Navajo - 90% within 60 miles		95.3%			94.1%		
Yavapai - 90% within 60 miles		100%			100%		
Yuma - 90% within 60 miles			99.9%	99.9%			
Pinal - 90% within 60 miles	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Cochise - 90% within 60 miles			100.0%	100.0%			
Santa Cruz - 90% within 60 miles			100.0%	100.0%			
Graham - 90% within 60 miles			100.0%	100.0%			
La Paz - 90% within 60 miles			100.0%	100.0%			
Greenlee - 90% within 60 miles			99.8%	99.8%			

Indicates in compliance with October 1, 2022 Telehealth modification to time and distance standards

Percent Compliant
90- 100%
80-89.9%
Under 80%
MCO Not in County

Table XIV – ALTCS-EPD and DES/DDD Behavioral Health Outpatient/Integrated Clinics (Adults)

ALTCS EPD and DDD Behavioral Health Outpatient/Integrated Clinics (Adults)					
SFY 2022					
County/Requirement	Banner University (L)	Mercy Care (L)	United Health Care (L)	Mercy Care (D)	United Health Care (D)
Maricopa - 90% within 15 min or 10 miles	99.2%	99.3%	99.3%	97.8%	98.6%
Pima - 90% within 15 min or 10 miles	99.1%	98.6%		95.6%	98.1%
Apache - 90% within 60 miles			97.7%	57.1%	66.9%
Coconino - 90% within 60 miles			100.0%	95.9%	98.6%
Gila - 90% within 60 miles	100%	100%	100.0%	100.0%	100.0%
Mohave - 90% within 60 miles			100.0%	100.0%	99.9%
Navajo - 90% within 60 miles			100.0%	100.0%	98.2%
Yavapai - 90% within 60 miles			100.0%	100.0%	100.0%
Yuma - 90% within 60 miles	99.9%			100.0%	100.0%
Pinal - 90% within 60 miles	100.0%	100.0%	100.0%	100.0%	100.0%
Cochise - 90% within 60 miles	100.0%			100.0%	100.0%
Santa Cruz - 90% within 60 miles	100.0%			100.0%	100.0%
Graham - 90% within 60 miles	100.0%			100.0%	100.0%
La Paz - 90% within 60 miles	100.0%			100.0%	100.0%
Greenlee - 90% within 60 miles	100.0%			100.0%	100.0%

Indicates in compliance with October 1, 2022 Telehealth modification to time and distance standards

Percent Compliant
90- 100%
80-89.9%
Under 80%
MCO Not in County

Table XV - ACC BH Outpatient/Integrated Clinics (Pediatric)

ACC BH Outpatient/Integrated Clinics (Pediatric)							
SFY 2022							
County/Requirement	Mercy Care (A)	Health Choice Arizona (A)	Arizona Complete Health (A)	Banner UFC (A)	Care1st (A)	Molina Complete Care (A)	United Health Care (A)
Maricopa - 90% within 15 min or 10 miles	98.7%	99.0%	99.0%	99.3%	99.1%	98.6%	99.0%
Pima - 90% within 15 min or 10 miles			97.2%	97.4%			97.2%
Apache - 90% within 60 miles		84.8%			71.2%		
Coconino - 90% within 60 miles		96.2%			97.4%		
Gila - 90% within 60 miles	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Mohave - 90% within 60 miles		100.0%			99.9%		
Navajo - 90% within 60 miles		94.4%			91.2%		
Yavapai - 90% within 60 miles		100.0%			100%		
Yuma - 90% within 60 miles			100.0%	99.9%			
Pinal - 90% within 60 miles	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Cochise - 90% within 60 miles			100.0%	100.0%			
Santa Cruz - 90% within 60 miles			100.0%	100.0%			
Graham - 90% within 60 miles			100.0%	100.0%			
La Paz - 90% within 60 miles			100.0%	100.0%			
Greenlee - 90% within 60 miles			100.0%	100.0%			

Indicates in compliance with October 1, 2022 Telehealth modification to time and distance standards

Percent Compliant
90.0- 100.0%
80.0-89.9%
Under 80.0%
MCO Not in County

Table XVI – Access to Care ALTCS-EPD and DES/DDD BH Outpatient/Integrated Clinics (Pediatric)

ALTCS EPD and DDD Behavioral Health Outpatient/Integrated Clinics (Pediatric)					
SFY 2022					
County/Requirement	Banner University (L)	Mercy Care (L)	United Health Care (L)	Mercy Care (D)	United Health Care (D)
Maricopa - 90% within 15 min or 10 miles	97.1%	98.8%	100.0%	98.0%	98.8%
Pima - 90% within 15 min or 10 miles	94.0%	96.2%		93.9%	96.8%
Apache - 90% within 60 miles			100.0%	100.0%	66.7%
Coconino - 90% within 60 miles			100.0%	100.0%	94.1%
Gila - 90% within 60 miles	100.0%	100.0%		100.0%	100.0%
Mohave - 90% within 60 miles			100.0%	100.0%	100.0%
Navajo - 90% within 60 miles			10.00%	100.0%	96.4%
Yavapai - 90% within 60 miles			100.0%	100.0%	100.0%
Yuma - 90% within 60 miles	100.0%			100.0%	99.7%
Pinal - 90% within 60 miles	100.0%	100.0%	100.0%	100.0%	100.0%
Cochise - 90% within 60 miles	100.0%			100.0%	100.0%
Santa Cruz - 90% within 60 miles	100.0%			100.0%	100.0%
Graham - 90% within 60 miles	100.0%			100.0%	100.0%
La Paz - 90% within 60 miles				100.0%	100.0%
Greenlee - 90% within 60 miles				100.0%	100.0%

Percent Compliant
90.0- 100.0%
80.0-89.9%
Under 80.0%
MCO Not in County
^ Less than 5 members in this population
0 Members in this population

Table XVII – Access to Care Crisis Stabilization Facility

Crisis Stabilization Facility* SFY 2022			
County/Requirement	Mercy Care (R)	Health Choice Arizona (R)	Arizona Complete Health (R)
Maricopa - 90% within 15 min or 10 miles	99.5%		
Pima - 90% within 15 min or 10 miles			98.3%
Apache - 90% within 45 miles		99.6%	
Coconino - 90% within 45 miles		99.5%	
Gila - 90% within 45 miles		100.0%	
Mohave - 90% within 45 miles		99.3%	
Navajo - 90% within 45 miles		99.8%	
Yavapai - 90% within 45 miles		99.4%	
Yuma - 90% within 45 miles			99.8%
Pinal - 90% within 45 miles			100.0%
Cochise - 90% within 45 miles			99.8%
Santa Cruz - 90% within 45 miles			100.0%
Graham - 90% within 45 miles			99.9%
La Paz - 90% within 45miles			92.8%
Greenlee - 90% within 45 miles			100.0%

** This standard only applies to ACC-RBHAs*

Percent Compliant
90.0- 100.0%
80.0-89.9%
Under 80.0%
MCO Not in County

Appointment Availability

Appointment availability includes timeliness standards for access to urgent and routine care appointments for various services including behavioral health provider appointments as follows:

Behavioral Health Provider Appointments:

1. Urgent need appointments as expeditiously as the member's health condition requires but no later than 24 hours from identification of need.
2. Routine care appointments:
    i) Initial assessment within seven calendar days of referral or request for service,
    ii) The first behavioral health service following the initial assessment as expeditiously as the member's health condition requires but:
        a. For member aged 18 years or older, no later than 23 calendar days after the initial assessment, or
        b. Members under the age of 18 years old, no later than 21 days after the initial assessment.
    iii) All subsequent behavioral health services, as expeditiously as the member's health condition requires but no later than 45 calendar days from identification of need.

Psychotropic Medications:

1. Assess the urgency of the need immediately, and
2. Provide an appointment, if clinically indicated, with a behavioral health medical professional within a timeframe that ensures the member
    i) Does not run out of needed medications, or
    ii) Does not decline in their behavioral health condition prior to starting medication, but no later than 30 calendar days from the identification of need.

AHCCCS requires MCOs to conduct provider appointment availability reviews on a quarterly basis to assess the availability of routine and urgent appointments for behavioral health appointments. These reviews typically consist of contact with providers to obtain information through a phone survey or in-person meeting review of appointment schedules. As displayed in the tables, some plans combine their reviews and apply them to more than one line of business, while others conduct and report their surveys separately.

The MCO must utilize the results to address access to care concerns and to assure appointment availability. In its network planning process, AHCCCS requires each plan to compare its current year's appointment availability results to the previous year to identify network gaps. MCOs must address when providers do not meet these timeframes and typically resurvey them the following quarter. Tables XVIII and XIX on the following pages display the percentage of providers meeting the timeframes for each ACC (A), ACC-RBHA, ALTCS-EPD (L) and ALTCS-EPD plan (R).

As noted earlier, due to the acquisition of Care1st's parent company by the parent company of Arizona Complete Health, members enrolled in Maricopa, Pinal, and Gila counties were transitioned to Arizona Complete Health effective October 1, 2021. As a result, the performance reported for Care1st in these counties is based upon the reporting period prior to the transition. Additionally, in December 2021 AHCCCS met with United Healthcare concerning its performance under this standard, which culminated in a September 30, 2022 Letter of Concern and corrective action plan. AHCCCS will monitor the MCO during SFY2023 for performance improvement.

Table XVIII – ACC-RBHA and ACC – Appointment Availability

ACC-RBHA and ACC Plans % of Sampled Providers Meeting Standard SFY 2022 Average	Mercy Care ®	Health Choice Arizo®(R)	Arizona Complete H®th (R)	Mercy Care (A)	Health Choice Arizona (A)	Arizona Complete Health (A)	Banner UFC (A)	Care1st (A)	Molina Complete Care (A)	United Health Care (A)
Urgent Need Appointments: As expeditiously as the member's health condition requires but no later than 24 hours from identification of need.	100.0%	100.0%	98.9%	100.0%	100.0%	98.9%	98.6%	99.3%	100.0%	70.5%
Routine: Initial assessment within seven calendar days of referral or request for service.	97.4%	100.0%	99.2%	99.0%	100.0%	99.2%	99.3%	99.3%	100.0%	77.8%
Routine: The first behavioral health service following the initial assessment as expeditiously as the member's health condition requires but for members aged 18 years or older, no later than 23 calendar days after the initial assessment.	99.2%	100.0%	99.4%	98.1%	100.0%	99.3%	98.3%	99.3%	100.0%	68.7%
–Routine - All subsequent behavioral health services, as expeditiously as the member's health condition requires but no later than 45 calendar days from identification of need.	100.0%	100.0%	99.5%	100.0%	100.0%	99.5%	99.2%	99.0%	100.0%	85%
Referrals for Psychotropic Medications: Provide an appointment, if clinically indicated, with a Behavioral Health Medical Professional within a timeframe that ensures the member a) does not run out of needed medications, or b) does not decline in their behavioral health condition prior to starting medication, but no later than 30 calendar days from the identification of need.	99.4%	100.0%	93.8%	97.2%	100.0%	93.8%	100.0%	94.6%	100.0%	89.1%

Percent Compliant
90.0- 100.0%
80.0-89.9%
Under 80.0%

Table XIX - ALTCS-EPD and DES/DDD - Appointment Availability

ALTCS-EPD and DES/DDD Plan % of Sampled Providers Meeting Standard SFY 2022 Average	Banner University (L)	Mercy Care (L)	United Health Care (L)	Mercy Care (D)	United Health Care (D)
Urgent Need Appointments: As expeditiously as the member's health condition requires but no later than 24 hours from identification of need.	98.6%	100.0%	70.5%	100.0%	70.5%
Routine: Initial assessment within seven calendar days of referral or request for service.	99.3%	99.0%	77.8%	97.5%	77.8%
Routine: The first behavioral health service following the initial assessment as expeditiously as the member's health condition requires but for members aged 18 years or older, no later than 23 calendar days after the initial assessment.	99.0%	98.1%	68.9%	93.6%	68.9%
Routine: All subsequent behavioral health services, as expeditiously as the member's health condition requires but no later than 45 calendar days from identification of need	99.2%	100.0%	85.0%	100.0%	85.0%
Referrals for Psychotropic Medications: Provide an appointment, if clinically indicated, with a Behavioral Health Medical Professional within a timeframe that ensures the member a) does not run out of needed medications, or b) does not decline in their behavioral health condition prior to starting medication, but no later than 30 calendar days from the identification of need.	100.0%	97.2%	89.1%	92.7%	89.1%

Percent Compliant
90.0- 100.0%
80.0-89.9%
Under 80.0%

Performance Metrics

AHCCCS utilizes performance metrics for monitoring MCO compliance related to the delivery of care and services to members.

Table XX provides specific behavioral health performance measures for the most recent, completed data available for the ACC program, for members designated as SMI enrolled with the ACC-RBHAs, and for managed care enrolled members across all lines of business for CY 2021. AHCCCS calculates performance measures on a Calendar Year (CY) to align with the most current federal fiscal year performance standards.

The access to care measures in Table XX continued to meet or exceed the NCQA Medicaid Mean despite declines in most measures when compared to the prior year. AHCCCS will continue to monitor these outcomes to ensure availability and access to behavioral health services.

Table XX – CY 2021 AHCCCS Performance Measure Data

CY 2021 Behavioral Health Performance Measure Rates				
Performance Measure	**2021 NCQA Medicaid Mean[1]**	**ACC Aggregate**	**SMI Aggregate**	**Statewide[2] Aggregate**
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence - 7 Day Follow-Up (Total) - NCQA	13.4%	15.8%	19.8%	18.3%
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence - 30 Day Follow-Up (Total) - NCQA	19.8%	22.2%	27.6%	25.1%
Follow-Up After Emergency Department Visit for Mental Illness - 7 Day Follow-Up (Total) - NCQA	40.1%	45.4%	53.9%	50.9%
Follow-Up After Emergency Department Visit for Mental Illness - 30 Day Follow-Up (Total) - NCQA	53.4%	55.7%	70.1%	63.3%
Follow-Up After Hospitalization for Mental Illness - 7 Day Follow-Up (Total) - NCQA	38.4%	42.5%	64.3%	57.8%
Follow-Up After Hospitalization for Mental Illness – 30 Day Follow-Up (Total) - NCQA	58.7%	58.8%	81.2%	74.3%
Follow-Up Care for Children Prescribed Attention-Deficit/ Hyperactivity Disorder (ADHD) Medication – Initiation Phase	39.7%	53.8%	NA	58.9%
Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication – Continuation and Maintenance Phase	50%	67.1%	NA	70.3%

[1] *NCQA Medicaid Mean retrieved from the State of Health Care Quality Report published by NCQA.*

[2] *Rates reflective of all managed care enrolled members meeting continuous enrollment criteria regardless of population/line of business.*

Conclusion

The delivery of physical and behavioral health care under an MCO integrated delivery system resulted in improved care coordination. Multiple efforts to improve the delivery of behavioral health services and the data elements in this report have occurred since SFY 2022. These efforts include participation in data sharing agreements, audit tool upgrades and evidence-based practice (EBP) training classes. AHCCCS improved the monitoring of the behavioral health system in SFY 2022, including:

- Enhanced the behavioral health audit tool so health care plans can better audit provider compliance and increase focus on member outcomes,
- Conducted network adequacy research on current behavioral health provider network in order to determine provider network development needs (focusing on specialty providers serving members with a developmental disability, SMI, and with co-occurring illness), and
- Participation in affinity groups through the Center for Medicare and Medicaid Services (CMS) to improve performance metrics.

AHCCCS will continue to use this data to improve health outcomes for AHCCCS members with co-occurring physical and behavioral health issues.